DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON, DC

OCT 2 2 2002

MEMORANDUM FOR SEE DISTRIBUTION

FROM: AFMOA/CC
110 Luke Avenue, Room 405
Bolling AFB, DC 20032

SUBJECT: Guidance for the 2002-2003 Influenza Immunizations and Surveillance Program

Air Force specific instructions for implementing the DoD Policy for the Use of Influenza Vaccine for 2002-2003 season (attachment 1) can be found in the Air Force Influenza Immunizations and Surveillance Program guidance (attachment 2). For the 2002-2003 influenza season, a sufficient supply of vaccine is available. Initial allotments have been shipped and full receipt is expected by mid-November. Immediate implementation of the influenza vaccination program, in accordance with guidance, is imperative.

While the AF influenza guidance is similar to those from previous years, please note the following two important recommendations: 1) MTFs should encourage providers to discuss influenza immunization with high-risk patients, especially pregnant women since they are at increased risk for complications but have not been targeted for influenza vaccination in previous years. 2) In addition to previous risk categories, the Advisory Committee on Immunization Practices encourages vaccination of infants aged 6-23 months and household contacts/out-of-home caretakers of children aged 0-23 months when feasible.

My POC for this memorandum is Maj Mylene Huynh, AFMOA/SGZP, 110 Luke Avenue, Room 405, Bolling AFB, DC 20032, (202) 767-4260, DSN 297-4260, e-mail: mylene.huynh@pentagon.af.mil.

PAUL B. CHRISTIANSON, Col, USAF, MC, SFS
Vice Commander
Air Force Medical Operations Agency
Office of the Surgeon General

Attachments:
1. ASD/(HA) Policy for the Use of Influenza Vaccine-2002-2003 Influenza Season (HA Policy: 02-019, 2 Oct 02)
2. 2002-2003 AF Influenza Immunizations and Surveillance Program (Oct 2002)

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THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

OCT 2 2002

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (MRAI&E)
DIRECTOR, JOINT STAFF

SUBJECT: Policy for the Use of Influenza Vaccine - 2002-2003 Influenza Season

The Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) have developed recommendations for the 2002-2003 influenza season. Their recommendations are based solely on clinical and epidemiological risk factors for mortality and morbidity from influenza, and do not address military readiness. Influenza vaccine manufacturers have informed the DoD of a delay of influenza vaccine availability throughout the United States for the 2002-2003 influenza season. Therefore, in consultation with the Joint Preventive Medicine Policy Group, prioritization recommendations are provided to assist commanders, resource managers, and force surgeons in balancing our primary mission of maintaining optimal medical readiness with our responsibility for protecting medically vulnerable beneficiaries. Ultimately, influenza vaccine prioritization is a local decision based upon availability of vaccine. DoD policy requires all active duty personnel and reserve personnel on active duty in excess of 30 days (10 days for Naval Reserve personnel) be vaccinated against influenza.

For the 2002-2003 influenza season, in addition to previously recommended risk categories, ACIP and CDC encourage the vaccination of infants 6-23 months of age, and household contacts and out-of-home caretakers of children 0-23 months of age. Target vaccination of these groups should take place after the vaccination of higher risk/higher priority groups (see attached "Influenza Vaccine Prioritization Recommendations").

For the 2002-2003 influenza season, the Department has contracted for 3.06 million doses – 75% from Aventis-Pasteur, and the remaining 25% from Wyeth. Aventis will deliver 562,500 doses by September 30, 2002, and the remainder not later than November 30, 2002. Wyeth will deliver 406,000 doses by October 15, 2002, and the remainder by December 16, 2002 or sooner. Services will utilize early vaccine doses to target high priority populations in accordance with the attached prioritization recommendations. Full-scale vaccination campaigns for other lower priority groups will be delayed until reasonable attempts have been made to vaccinate higher priority groups and vaccine supplies are adequate. Immunizations should begin as soon as the vaccine is received. The optimum time for vaccination is October and November. However, over the last 25 influenza seasons (1976-2001), the peak month for influenza activity occurred in December only 4 times (16%). For 19 seasons (76%), the peak activity occurred January through March. As such, vaccination efforts should continue until vaccine supplies are depleted or through March. Vaccination of recruits should continue until the expiration date on the vaccine label (expected to be June 30, 2003). Steps to minimize wastage of vaccine are important, including refraining from stockpiling more vaccine than needed resulting in vaccine

being unused. Any influenza vaccine from previous years cannot be used for the 2002-2003 season.

The US Air Force continues to be the executive agent for laboratory-based influenza surveillance. Sentinel sites are selected based on their location, mission, and training status. Installations interested in participating may contact the Air Force Institute of Environment, Safety, and Occupational Health Risk Analysis (AFIERA) by email at INFLUENZA@brooks.af.mil for further details. The Epidemiology Branch of AFIERA updates the influenza surveillance website (https://gumbo.brooks.af.mil/pestilence/influenza) twice each week during the influenza season. Results from the laboratory surveillance are reported weekly during the flu season in the DoD Weekly Influenza Surveillance Report published by the AFIERA.

In addition to this laboratory-based surveillance data, AFIERA will analyze data from the DoD Global Emerging Infection System (GEIS) Electronic System for the Early Notification of Community-based Epidemics for influenza-like illnesses, and DoD hospitalization data for influenza and influenza-related hospitalizations, and include these data in the weekly report. Monthly summary and final reports will be coordinated between AFIERA and DoD GEIS for submission to Health Affairs.

My point of contact at Health Affairs is COL Benedict Diniega, (703) 681-1711.

William Winkenwerder, Jr., MD

Attachment:
As stated

Copy to:
J-4 (HSSD)
Surgeon General, Army
Surgeon General, Navy
Surgeon General, Air Force
Director of Health and Safety, US Coast Guard
Director, TRICARE Management Activity
Defense Supply Center Philadelphia (ATTN: Mr. Fileccia)
Assistant Secretary of Defense (Reserve Affairs)

Influenza Vaccine Prioritization Recommendations for the 2002-2003 Influenza Season

1. This year, DoD has ordered 3.06 million doses of influenza vaccine from Aventis-Pasteur (75%) and Wyeth (25%). Aventis will deliver 562,500 doses by September 30, 2002 and the remainder NLT November 30, 2002. Wyeth will deliver 406,000 doses by October 15, 2002 and the remainder by December 16, 2002 or sooner.

2. The following prioritization (Priority 1-highest priority, Priority 7-routine priority) seeks to balance our primary task--maintain optimal military readiness--with our responsibility to protect our most vulnerable populations. Where possible, vaccination of mission critical military personnel and high-risk medical individuals will proceed in parallel (Priorities 1, 2, and 3). For eligible beneficiaries, Military Treatment Facilities (MTFs) and operational force surgeons should prioritize administration of influenza vaccine in the following order:

a. Priority 1:

1) Priority 1A: Operational military personnel (Service-specific determination):

a) Operational forces forward deployed in support of Combatant Commander operational requirements in areas of high security risk (e.g., Southwest Asia, Korea, Eastern Europe, "STANS");

b) Forces embarked or afloat two or more weeks (may include pre-deployment underway work-up periods) (vaccine should be administered at least two weeks prior to getting underway);

c) Other forward deployed forces;

d) Special duty personnel expected to regularly transit multiple geographic areas or otherwise pose particular operational and epidemiologic risks, such as airlift aircrews. Ideally, vaccine should be administered at least two weeks prior to deployment;

e) Those on 96-hour alert status, and other alert forces as defined by the joint regulation on Immunizations and Chemoprophylaxis;

f) Early deployers through C+14.

2) Priority 1B. Defense Enrollment Eligibility Reporting System (DEERS) enrollees, whether or not on active duty, with high-risk medical conditions including:

a) Persons age 65 years of age and older enrolled in TRICARE Senior Prime at an MTF, or who otherwise receive the majority of their medical care at the MTF through an identified primary care manager (PCM) or ongoing patient-provider relationship. This age group historically has about 90% of the mortality from pneumonia and influenza;

b) Adults and children with chronic disorders of the pulmonary or cardiovascular system, including asthma;

c) Adults and children who have required regular medical follow-up or hospitalization during the preceding year for chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by human immunodeficiency virus);

d) Residents of long term care facilities (where applicable);

e) Women who will be in the second or third trimester of pregnancy during the influenza season. Pregnant women who have medical conditions that increase their risk for complications from influenza should be vaccinated, regardless of the stage of pregnancy;

f) Children and teenagers (age 6 months to 18 years) who are receiving long-term aspirin therapy, and therefore might be at risk for developing Reye's syndrome after influenza infection. Since high-risk children aged<9 years who are receiving vaccine for the first time need a booster dose 1 month after the initial dose, vaccinate these children as early as possible.

b. Priority 2: Health-care workers (including civilian employees and volunteers) with direct patient contact (due to the increased potential to transmit influenza virus infection to high-risk persons).

c. Priority 3: Trainee populations, including basic and advanced trainees, academy students and officer trainees. Trainees are at higher risk for epidemic influenza, but are theoretically easier to prophylax against influenza A than operational active duty members. Epidemiologic data suggest influenza B is less common than influenza A, particularly in these groups, and influenza B incidence usually peaks later in the season when vaccine supplies may be more widely available. Trainee groups should be under special hand-washing precautions at all times to reduce person-to-person transmission of respiratory viruses, including influenza and adenovirus.

d. Priority 4: Other groups in close contact with high-risk persons, such as employees in long term care facilities, household members (age 6 months and older) of medically high risk patients, and military training instructors.

e. Priority 5: All other military members in priority for deployment (those scheduled to deploy, then those on mobility status).

f. Priority 6: Other active duty members (including Guard and Reserve on active status) and emergency essential DoD civilians at OCONUS facilities:

1) Between 50 and 64 years of age;

2) Younger than 50 years of age.

g. Priority 7: All other beneficiaries:

1) Between 50 and 64 years of age;

2) Infants age 6 months through 23 months;

3) Household contacts (age 6 months and older) and out-of-home caretakers of children age 0 day to 24 months;

4) All other beneficiaries.

(Note: This priority scheme may be altered in the event of an epidemic outbreak requiring a focused management effort for a specific population. Alteration of priorities will be at the direction of the Service epidemiology centers and higher headquarters (SG) level preventive medicine authority.)

3. For other recommendations and guidance to include the use of diagnostics and antiviral drugs, and mass immunization campaigns, please refer to the Advisory Committee on Immunization Practices (ACIP) statement on the Prevention and Control of Influenza in the Center for Disease Control and Prevention (CDC) Morbidity and Morbidity and Mortality Weekly Report (MMWR) dated April 12, 2002 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm).

4. Delay mass vaccination campaigns for lower risk beneficiaries (Priority 7) until the beginning of December when most vaccine should be delivered.

5. Health care providers should be reminded that influenza is a reportable medical event for the DoD Reportable Medical Events System (RMES). Reported cases should meet the definition for a confirmed case of influenza contained in the Tri-Service Reportable Events document which is available on the Army Medical Surveillance Activity website (http://amsa.army.mil/AMSA/amsa.ns.home.htm). Confirmed influenza cases should be reported promptly to the Service surveillance center utilizing existing Service-specific reportable medical events systems.

- Army Medical Surveillance Activity (AMSA)
  DSN 662-0471 http://amsa.army.mil/AMSA/amsa_homc.htm
  CML (202) 782-0471

- Navy Environmental Health Center (NEHC)
  DSN 377-0700 http://www-nehc.med.navy.mil/
  CML (757) 953-0700
- Air Force Institute of Environment, Safety, and Occupational Health Risk Analysis (AFIERA)
  DSN 240-3471 https://gumbo.brooks.af.mil/pestilence/influenza
  CML (210) 536-3471

- Coast Guard Directorate of Health and Safety (G-WKH-1)
  COMM (202) 267-1725 e-mail sludwig@comdt.uscg.mil

2002-2003 Air Force Influenza Immunizations and Surveillance Program

1. References:

(a) Assistant Secretary of Defense, Health Affairs (ASD(HA)) memorandum, dated 2 October 2002, subject: Policy for the Use of Influenza Vaccine--2002-2203 Influenza Season. http://www.ha.osd.mil/policies/2002/02-019.pdf

(b) CDC Influenza Home Page (provider's information, supply concerns and updates, public affairs and media materials, and patient education materials). http://www.cdc.gov/nip/flu

(c) CDC Patient education materials, printable materials and flyers for waiting rooms, tips for mass immunization campaigns, vaccine immunization statements (VIS). Updated 3 Oct 02. http://www.cdc.gov/nip/flu/Provider.htm#Education

(d) Morbidity and Mortality Weekly Report, Volume 46, Number RR-18, 26 December 1997, subject: Immunization of health care workers: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). http://www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm

(e) Morbidity and Mortality Weekly Report, Volume 51, number RR-3, 12Apr 2002, pp1-31, subject: Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm

(f) Morbidity and Mortality Weekly Report Volume 51, number 23, p. 503-506. 14 June 2002, subject: Update: Influenza Activity --- United States and Worldwide, 2001--2002 Season, and Composition of the 2002--03 Influenza Vaccine http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5123a3.htm

(g) Morbidity and Mortality Weekly Report, Volume 46, Number RR-8, 4 April 1997, subject: prevention of pneumococcal disease: recommendations of the Advisory Committee on Immunization Practices (ACIP). http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm

This message supersedes all others, same subject.

2. *Purpose:* This message provides specific Air Force guidance, expanding and clarifying ASD(HA) memo (reference (a)), for the Air Force. Request dissemination of this message to all medical treatment facilities (MTFs), MTF/CC, immunization point of service/clinics, public health offices, pharmacy services, and medical logistic/supply sections. Please pass this message to your influenza vaccine manager and immunization activities. The influenza immunization program typically runs from 1 Oct 02 to 31 Mar 03; however, influenza vaccination should be considered year-round for travelers to the tropics and seasonally for the southern hemisphere (northern hemisphere summer). DoD Influenza Surveillance Program runs all year long.

3. *2002/2003 Influenza virus vaccines and its availability:* Sequential release with sufficient quantity and no significant delay in vaccine delivery is anticipated for flu season 2002-2003. DoD has contracted with Aventis-Pasteur (75%) and Wyeth (25%). Shipment to Defense Supply Center Philadelphia (DSCP) of a full supply is expected by mid-November 2002, in adequate time for the (historic) seasonal peak for influenza (usually January through March). Mass-vaccination campaigns should follow a) receipt of a majority of vaccine and b) targeted vaccination of groups and individuals in higher priorities. For prioritization and clinical issues regarding medically high-risk individuals, see paragraph 4 (*Target groups and specific instructions for influenza immunization*), reference (e), and Appendix 1. Prioritization scheme may be altered

in the event of an epidemic outbreak requiring focused management of a specific population. If necessary, alteration of priorities will be given at the direction of AFMOA/SGZP.

a. Air Force Medical Logistics (AFMLO) is responsible for ordering influenza vaccine for all AF activities. Each activity will be notified by letter of the quantities ordered and the document numbers being used. AFMLO incorporated initial estimates of high-risk individuals in the spreadsheet used to prioritize vaccine distributions. Improvements in these estimates are anticipated, with input from Population Health Support Division (PHSD) AFMOA/SGZZ. Any additional quantities required must be coordinated with AFMLO/FOP, Attn: Jackie Snoots, DSN: 343-4162, commercial (301) 619-4162. Key information and documents will be posted on the AFMLO influenza website at https://afml.ft-detrick.af.mil/afmlo/fom-p/flumenu.cfm.

National Stock Numbers (NSN's) for the vaccine are:

a. NSN 6505-01-493-3783 INFLUENZA VIRUS VACCINE, USP, Trivalent, Vial, 0.5ml, 10 dose, 1's, Trivalent Split Virus Only, 2002/2003 influenza season; for immunizing persons 6 months of age and older U/I: VI

b. NSN 6505-01-493-4030 INFLUENZA VIRUS VACCINE, USP, Trivalent, Syringe-Needle Unit, 0.5 ml, 1 dose, 10's, Trivalent Split Virus Only, 2002/2003 influenza season; for immunizing persons 6 months of age and older U/I: PG

b. All vaccines procured under current contracts will expire **30 June 2003**. Vaccine condition on arrival: Should **not** have been **frozen**. If the enclosed temperature monitor's indicator light is red, do not issue to users until serviceability is confirmed by the "Temp Tales" monitor at DSCP. Follow instructions enclosed with each shipment. Refrigerate immediately on arrival and store at 2-8° Centigrade (35° and 46° Fahrenheit). **Do not freeze:** Do not put vaccine directly on ice during local transport. Place cold pack in cooler and let temperature stabilize for 5-10 minutes, check temperature with thermometer (between 2° to 8° is best per manufacturer's recommendation when transporting vaccine), place vaccine in the container after temperature is stable. Shake vial vigorously before withdrawing each dose. Shelf life: good until expiration date, if not contaminated.

Pre-drawing vaccine increases the chance of wastage or decreased potency; therefore, draw and administer vaccine IAW ACIP guidelines. In certain circumstances where a single vaccine type is being used (e.g., in advance of a community influenza vaccination campaign), filling multiple syringes before their immediate use can be considered. Care should be taken to ensure that the cold chain is maintained until the vaccine is administered.

When the syringes are filled, the type of vaccine, lot number, and date of filling must be carefully labeled on each syringe, and the doses should be administered as soon as possible after filling. When in doubt, refer to manufacturer's recommendations in the package insert for detailed instructions

4. ***Target groups and specific instructions for influenza immunization*:** Prioritization for all targeted groups will be in accordance with the published ASD(HA) policy on this topic (see reference (a) above). Detailed information for groups to be immunized is contained in that document, as well as in references (b) through (e). For quick reference, refer to a single-sheet version of the prioritization, Appendix 1, which can be posted in point-of-service and other immunization locations. MTFs should ensure communication of plan and of local strategies to all involved parties, as listed in paragraph 2. Public affairs resources are available through CDC at reference (b) or http://www.cdc.gov/nip/flu.

Remember that persons with certain underlying medical conditions will also benefit from pneumococcal vaccination (if previously unvaccinated) early in the influenza season, achieving substantial protection from a major complication of influenza, secondary bacterial pneumonia. **MTFs should identify eligible individuals and use opportunity during influenza campaign to ensure that these individuals are up to date on pneumococcal vaccination,** in accordance with ACIP recommendations (reference (f) or http://www.cdc.gov/mmwr/preview/mmwrhtml/00047135.htm.

a. **MTFs are urged to use reminder-recall and self-identification systems to increase vaccination for medically high-risk individuals**. The Population Health Support Division (PHSD) provides MTFs' patient enrollment data through the AF Population Health Portal (AFPHP). MTFs should identify high-risk patients (by age and chronic disease diagnoses such as diabetes, asthma, and COPD) for reminder recall.

MTFs can contact PHSD (helpdesk DSN 240-8190 Comm. (210) 536-8190 email: phso.helpdesk@brook.af.mil) for information about accessing the AFPHP. Standing orders (developed and used locally at MTFs) and standard operating procedures may be useful (e.g., anyone age 65 or older may walk in and receive flu vaccine, hospitalized patients receive flu vaccine prior to discharge, pregnant women > 14 weeks Estimated Gestational Age (EGA) are reminded to receive vaccine during routine prenatal care, etc.).

In order to facilitate self-identification of high-risk patients, CDC developed self-identification questionnaires and clinic posters available from CDC website at reference (e) or http://www.cdc.gov/nip/flu/Provider.htm#Education. **All MTFs and clinics should post these materials in patient care areas, waiting rooms, prenatal and immunization clinics, and other areas likely to target those in high-risk groups. MTFs should particularly target pregnant women > 14 weeks EGA through provider education (i.e., increase providers' awareness of ACIP recommendations, reference (e) or** http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm) **and by encouraging providers to discuss influenza vaccine with their pregnant patients.**

b. The following are detailed instructions for vaccination of specific age groups and categories:

1). *Active duty members:* 1 dose (0.5 ml) each, split virus vaccine. NSN 6505-01-493-3783 or 6505-01-493-4030

2). *Non active duty adults:* high risk based on self-identification, AF Population Health Portal (AFPHP) data, or on recommendation of health care provider; by patient request once full vaccine supply becomes available- 1 dose (0.5 ml) split virus vaccine, NSN 6505-01-493-3783 or 6505-01-493-4030

3). *Child dependents:* high risk upon recommendation of health care provider, AFPHP data, or upon parent/guardian request once full vaccine supply becomes available. Two doses of split virus, given one month apart, are recommended for infants and young children < 9 years who are receiving influenza vaccine for the first time. NSN 6505-01-493-3783 or 6505-01-493-4030. For recommendation on vaccine use among young children, see page 11 of reference (e) or http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5103a1.htm.

5. Virus strains for the above NSN's are as follows: A/Moscow/10/99(H3N2)-like A/New Caledonia/20/99(H1N1)-like and B/Hong Kong/330/2001-like virus strain. The B virus is the only change from last year. For the A/Moscow/10/99 (H3N2)-like antigen, US manufacturers will use the antigenically equivalent A/Panama/2007/99 (H3N2) virus. These viruses will be used because of their growth properties and because they are representative of currently circulating A (H3N2) and B viruses.

6. Left over 2001-2002 vaccines from last year's program will not be used for the 2002-2003 program. This message is your authority to destroy any vaccine remaining from last year's program.

7. ***Documentation:*** Consistent with AF policy (AF memo June 2000) all influenza and pneumococcal vaccination will be documented in Air Force Complete Immunization Tracking Application (AFCITA). Mass immunization and workplace vaccination campaign planning must consider this requirement for AD, Reserve Component and DoD beneficiaries (e.g., automated methods on-site or manual lists at vaccination site compiled and used to update AFCITA). The Air Force Corporate Health Information Processing Service (AFCHIPS) website provides base-level influenza immunization completion data throughout influenza season: https://www.afchips.brooks.af.mil/main.htm.

8. ***Contraindications*:** Influenza vaccine should not be administered to persons with known anaphylactic hypersensitivity to eggs or to other components of the influenza vaccine without first consulting a physician (information on vaccine components can be found in package inserts). Persons who have a history of anaphylactic hypersensitivity to vaccine components but who are also at high risk for complications from influenza may benefit from vaccine after appropriate allergy evaluation and desensitization. Persons with a moderate to severe acute illness normally should not be vaccinated until their symptoms have improved. **Minor illnesses with or without fever do not contraindicate the use of influenza vaccine, particularly among children with minor upper respiratory tract infection or allergic rhinitis.** Mild systemic reaction with fever, malaise, myalgia, and local redness at the injection site should not be considered allergic to

influenza vaccine. These side effects are self-limiting and resolve quickly. Neither pregnancy nor breastfeeding is a contraindication. Pregnant women who have medical conditions that increase their risk for complications from influenza should be vaccinated, regardless of the stage of the pregnancy.

9. ***Side effects and adverse reactions:*** When educating patients regarding potential side effects, it should be emphasized that a) inactivated influenza vaccine contains noninfectious killed viruses and cannot cause influenza; and b) coincidental respiratory disease unrelated to influenza vaccination can occur after vaccination.

Local reactions (affecting 10-64% of patients) include soreness at the vaccination site and can last up to 2 days. Systemic reactions include fever, malaise, myalgia, and other systemic symptoms, beginning 6-12 hours after vaccination, can persist for 1-2 days. Immediate reactions, presumably allergic (e.g., hives, angioedema, allergic asthma, and systemic anaphylaxis) rarely occur after influenza vaccination. Reports of vaccine adverse events must be mailed within seven days of occurrence. A form VAERS-1 should be submitted to the Food and Drug Administration's (FDA) vaccine adverse events reporting system, P.O. Box 1100, Rockville, MD 20849-1100 and to 311HSW/AFIERA/RSRH, Epidemiology Surveillance Branch, 2513 Kennedy Circle, Brooks City Base, Texas 78235-5116. Incidents that are considered life threatening or that result in death must be reported to 311 HSW/AFIERA/RSRH within 24 hours. The VAERS form may be downloaded from the FDA website http://www.fda.gov/cber/vaers/vaers.htm.

10. ***ANG and AFRES activities:***

For Air National Guard (ANG) activities: ANG medical squadrons may submit their requirement for influenza virus (flu) vaccine either through their host medical stock record account (Medical Supply), which is the preferred method or through the Office of the Air Surgeon, Air National Guard Readiness Center (ANGRC). Units should submit their requirement to the ANGRC if they elect to have the vaccine shipped directly to their local stock record account (Base Supply). In this case, the AFMLO will assign the requisition number and process the requisition at the appropriate time.

Regardless of which flu vaccine submission channel is selected, the AFMLO will notified each ANG medical squadron, via a separate memorandum, that the squadron's vaccine requirement has been received and processed as well as relay any other pertinent information. If additional vaccine is required, contact TSgt Piers Heriz-Smith, Program Manager, Medical Logistics, ANGRC at DSN 278-8577 or by e-mail at Piers.Heriz-Smith@ang.af.mil or by FAX at (301) 836-7446.

For Air Force Reserve activities: AFRES activities will need to contact host (FM) account for their requirements. Contact Ron Martin (HQ AFRC/SGSL) at DSN 497-1905 or com. 478-327-1905; or by e-mail at ronald.martin@afrc.af.mil.

11. ***DoD Influenza Surveillance Program (formerly known as Project Gargle):*** DoD Influenza Surveillance Program is an ASD(HA) directed influenza surveillance program and will be continued during the 2002-2003 season. Intensive surveillance efforts ensure early identification of influenza outbreaks and identify the circulating influenza virus. Preventive measures such as disease surveillance and immunizations reduce influenza morbidity and mortality. The medical facility commanders at MTFs designated as sentinel sites are responsible for their base DoD Influenza Surveillance Program.

a. *Case definition Influenza-like Illness (ILI):* Case definition includes patients with fever (> or equal to 100.5 ° Fahrenheit/38° Centigrade, oral or equivalent), and cough or sore throat (<72 hours duration) OR patients with clinical radiographic evidence of acute non-bacterial pneumonia. Swabs should be taken from patients fitting the case definition and from any individual with acute non-bacterial pneumonia or symptoms compatible with influenza activity. The population to be sampled for the DoD Influenza Surveillance Program includes dependents and active duty. Sampling early in the course of illness is desirable, since the amount of virus in the throat decreases rapidly during the course of the illness.

b. *Sentinel bases* are encouraged to institute an active influenza surveillance and identification program in which the influenza incidence rate is determined and tracked over time.

c. *Etiological sentinel bases are*: Andersen AB GU, Andrews AFB MD, Elmendorf AFB AK, Ft Lewis WA, Hickam AFB HI (in coord with NEPMU-6), Incirlik AB TU, Kadena AB JA, Kunsan AB SKO, Lakenheath RAFB UK, Little Creek NAB VA, Maxwell AFB AL, McGuire AFB NJ, Misawa AB JA, Pearl Harbor NH HI, Osan AB SKO, Ramstein AB GE, Sheppard AFB TX, Travis AFB CA, Tripler AMC HI, USAF Academy CO, Yokosuka Naval Station JA, and Yokota AB JA. *Specimen submission*

requirements: weekly, each sentinel base will submit at least 6 throat or nasal swab specimens to 311HSW/AFIERA/SDE during active influenza season, from October through May. Additional samples can be sent, especially during influenza outbreaks. Upon request, new viral transport system media kits will be sent to sentinel base public health offices by 311HSW/AFIERA/SDE. The kits will be sent with necessary collection information. Non-sentinel bases can also submit samples by obtaining the sampling kits from 311HSW/AFIERA/SDE, DSN 240-8378/1679.

d. *Population based sentinel bases are*: Lackland AFB TX, MCRD San Diego CA, NRTC Great Lakes IL, CGTC Cape May NJ, Ft Leonard Wood MO, Ft Jackson SC, Ft Benning GA, Ft Knox KY, Ft Sill OK and MCRD Parris Island SC. *Specimen submission requirements:* Weekly, each sentinel base will obtain viral throat or nasal culture specimens from a systematic sample of cases, not to exceed a rate of 2 specimens/1000 population/week. Specimens are preserved at -70°C and are shipped to Naval Health Research Center (NHRC) on dry ice every 4 weeks. In addition, sites will provide weekly numerator (# of cases) and denominator (population) data to NHRC, Emerging Illness Division. Viral transport system media kits will be sent to surveillance sites by NHRC. Further information on the population-based surveillance program is available from NHRC at http://pc176.nhrc.navy.mil/ or DSN 553-8097.

e. *Reporting*: Patients fitting the case definition with laboratory confirmation will be recorded as a reportable event and patient information entered in the respective service reportable event surveillance system (Air Force Reportable Events Surveillance System (AFRESS), Naval Disease Reporting System (NDRS), Army Reportable Medical Event System (RMES)) in accordance with DoD regulations. The reporting priority for the 2002/2003 season is ROUTINE. The base-level public health/prevention activity is required to monitor weekly ILI rates and report to 311HSW/AFIERA/RSRH (AF), any influenza-like outbreaks. Bases are no longer required to report the number of throat swabs submitted, the base population, or the number of upper respiratory/influenza-like illnesses except population based sentinel sites.

f. *Influenza-like illness suspected outbreaks:* All MTFs (Chief, Professional Staff, professional staff; laboratory officer; public health/preventive medicine officer; and infection control officer) should develop and flow-chart their process to ensure procedures for virus isolation are in place in the event of a potential viral epidemic. The process (from physician order through specimen collection to virus identification and reporting) should be reviewed and briefed annually (at the onset of influenza season) to all health care providers. Should ILI rates exceed normal background levels for a specific time period, Public Health is required to report the increase to 311HSW/AFIERA/RSRH and submit specimens to 311HSW/AFIERA/SDE. Specimen kits can be obtained by calling DSN 240-8378.

12. **POCs: Influenza vaccine supply, delivery, shortage and availability issues:** AFMLO/FOM-P, Fort Detrick, MD. POC: Jackie Snoots, AFMLO/FOP, DSN 343-4162 or (301) 619-4162, fax: DSN 343-6844 or (301) 619-6844, or email: jackie.snoots@ft-detrick.af.mil. Please direct questions to either Jackie Snoots (AFMLO/FOP) or SSgt Sherry Crandell, AFMLO/FOP, DSN 343-6852 or (301) 619-6852 or e-mail: sherry.crandell@ft-detrick.af.mil.

Policy and prioritization: AFMOA/SGZP POC Major Mylene Huynh, AFMOA/SGZP, 110 Luke Ave, Room 405, Bolling AFB, DC 20032-7050, DSN 297-4260 or (202) 767-4260, or e-mail mylene.huynh@pentagon.af.mil. Please direct questions to Major Mylene Huynh or MSgt Mark Mellinger.

DoD Influenza Surveillance: AFIERA/RSRH POC Major Jill Feig, 311HSW/AFIERA/RSRH, 2513 Kennedy Circle Brooks City Base, TX 78235-5116, DSN 240-3471, (210) 536-3471, fax DSN 240-6841, email influenza@brooks.af.mil, or visit the web site at https://gumbo.brooks.af.mil/pestilence/Influenza/. Please direct questions to Major Jill Feig. Laboratory questions may be directed to 311HSW/AFIERA/SDE. DSN 240-8378 or (210) 536-8378.

APPENDIX 1 DOD INFLUENZA VACCINE PRIORITIZATION

2002-2003 Influenza Season

Influenza vaccination should be administered in the following prioritization order:

September/October 2002

For operational efficiency, vaccinate those in priority groups 1, 2, and 3 during this time period

Priority 1 (Highest priority)

Priority 1A: Mission critical military personnel

a) Operational military personnel (deployed forces in areas of high security risk such as SW Asia, Korea, Eastern Europe)

b) Military members who are deployed aboard a ship for two or more weeks

c) Other forward deployed forces

d) Special duty personnel who regularly transit multiple geographic areas (i.e., airlift aircrews, including activated reserve airlift crews)

e) Military members who are on 96-hour alert status or other alert forces

f) Early deployers through C+14 (i.e., members of UTCs scheduled to deploy within first 14 days of contingency)

Priority 1B: DEERS enrollees

a) who are aged > 64 years

b) adults and children who have chronic high-risk medical conditions: pulmonary (e.g., asthma, COPD), cardiovascular (e.g., CHF), metabolic (e.g., diabetes), renal dysfunction, hemoglobinopathies, immunosuppression, including HIV infection

c) who are residents of long-term care facilities

d) who are pregnant and will be > 14 weeks gestation during influenza season

e) who are children (age 6 months to 18 years) on long-term aspirin therapy

Priority 2: Health care workers (including civilian employees and volunteers) with direct patient contact

Priority 3: Trainee populations (basic, advanced and officer trainees; academy students)

November 2002

Continue to vaccinate those in above priority groups and begin to vaccinate those in priorities 4-6

Priority 4: Other groups in close contact with high-risk persons (e.g., employees in long term care facilities, household members (age 6 months and older) of medically high-risk patients, and military training instructors)

Priority 5: All other military members in priority for deployment (those scheduled to deploy, then those on mobility status).

Priority 6: Emergency essential DoD civilians at OCONUS facilities and other active duty members (including Guard and Reserve on active status). Prioritize those 50-64 years of age before those < 50 years of age.

December 2002 through March 2003

Continue to vaccinate those in above priority groups and begin to vaccinate those in priority 7

Priority 7: All other beneficiaries (Routine Priority).

a) Prioritize those 50-64 years of age before those < 50 years of age

b) Infants 6 through 23 months of age

c) Household contacts and out-of-home caretakers of children aged 0 to 24 months

d) All other beneficiaries